Working Paper

Mutual Health Organizations: A Quality Information Survey in Ghana

November 2001

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Mission

Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:

- *Implementation of appropriate health system reform.*
- *Generation of new financing for health care, as well as more effective use of existing funds.*
- *Design and implementation of health information systems for disease surveillance.*
- *Delivery of quality services by health workers.*
- *Availability and appropriate use of health commodities.*

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Abstract

Mutual health organizations (MHOs), community-based health financing schemes, are becoming increasingly popular as an alternative financing mechanism in sub-Saharan Africa. One concern about these organizations is how they monitor quality of care provided. The survey reported on here was carried out in nine MHOs in Ghana in 2001 by the Partners for Health Reform*plus* project as part of a three-country study that looks at MHO conceptions of quality of care and how quality is built into MHO–provider agreements. This Ghana study found that several of the schemes studied are so young that they have not yet begun to administer benefits and thus had no historical data to report; but even those in full operation lacked record-keeping capacity. Five of the nine schemes operate without contracts, i.e., without record-keeping and monitoring requirements; in some cases, groups feel that quality monitoring and improvement is the responsibility of the central Ministry of Health. Nevertheless, the study found that many MHO managers are concerned about the issue of quality of care. There is need to help them implement steps to ensure a certain minimum standard of care.

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Foreword

This study of Mutual Health Organizations in Ghana is part of a PHR*plus* three-country study of efforts by mutual health organizations (MHOs) to ensure quality of care. The study will be synthesized in a technical report to be published by PHR*plus*, and lessons learned will be incorporated into a quality manual for MHO managers.

Acknowledgments

We would like to thank, especially, the interviewees of the various Mutual Health Organizations who gave their time often at short notice and cooperated fully with the interviewers during the data collection process.

They are:

- Mr. E, Pratt – Koforidua Diocese Methodist Mutual Health Scheme
- Dr. Dei Anane – St. Rose's Students Health Scheme, Akwatia
- Mr. Joseph T. Otoo – Regional Chairman, Civil Servants' Association, Kumasi
- Dr. Appiah Denkyira – Ashanti Regional Director of Health Services, Kumasi
- Mr. Kyeremeh Boateng – Scheme Coordinator, Tano Health Insurance Scheme, Tano
- Mr. Philibert Kankye – Executive Director, CHAG
- Mrs. Elizabeth Asare Kumi – Tano Health Insurance Scheme, Tano
- Mr. Mohammed Abbas – Scheme Coordinator, Manhyia Susu Health Scheme, Kumasi
- Dr. Obeng – Manhyia Susu Health Scheme, Kumasi
- Mr. Simon Unezumeh – Nkoranza Health Insurance Scheme, Nkoranza
- Dr. Ineke Bosman – Nkoranza Health Insurance Scheme, Nkoranza
- Mrs. Rose Akanko – Initiator/Manageress, Tiyumtaaba Welfare Association, Tamale
- Mr. James Duma – Manager, South Sissala Health Insurance Scheme, Funsi

1. Introduction

1.1 Background

Since 1996, the United States Agency for International Development (USAID) has been one of the organizations involved in community health financing and mutual health organizations (MHOs) in Ghana. Through the Partners for Health Reform*plus* project (PHR*plus*), USAID has forged important relationships with the Ministry of Health, other partners, and, most importantly, with MHOs themselves.

In accordance with its objectives and to support the development and sustainability of MHOs, PHR*plus* conducted a survey to understand further the activities of selected MHOs, in particular with regard to the quality of health care the MHOs deliver. It is envisaged that the results of the survey will lead to the creation of appropriate tools and mechanisms for MHOs to increase access to quality services and demand for quality services.

A sample of nine MHOs in five regions of Ghana – the Eastern, Ashanti, Greater Accra, Brong-Ahafo, and the Northern Regions – were surveyed.

1.2 Objectives of Study

Mutual health organizations are regarded as a vehicle for ensuring and improving quality in health care. The study aimed at:

- assessing what MHOs currently conceive as quality of service
- assessing to what extent quality of care is factored into MHO–provider arrangements.

The results of the study will be used to develop appropriate and user-friendly tools and mechanisms for MHOs to increase access to services that are of quality.

2. Methodology

2.1 Data Collection Tools

Two main data collection tools were used: a semi-structured questionnaire (see Annex) and informal discussions with the MHO managers.

The 42-item questionnaire comprised both open-ended and closed questions. The questions covered the following:

- background of the MHOs
- structure
- type of provider
- health care services provided
- quality of services
- MHO–service provider relationships.

To ensure quality of data collected, interviewers were trained on the use of the questionnaire and provided with general background information on the project, including its goals and objectives. A session was devoted for a thorough review of the questionnaire, and appropriate amendments and inclusions were agreed upon.

The questionnaires were administered to the nine MHOs during the field study and all responses and information was recorded. The questionnaires were administered in English. Prior to the interviews, the purpose of the survey was explained to the respondents. The interviewers then solicited their cooperation and assured them of confidentiality. On average it took 68 minutes to administer the questionnaires (Table 1).

Quantitative and qualitative data were analyzed using descriptive statistics and summarized in point form.

Table 1. Mutual Health Organizations Interview Schedule

MHO	Data Entry Date	Time Taken
Eastern Region		
St. Rose's Secondary School Health Insurance Scheme	18-11-01	90 minutes
Methodist Church Koforidua Diocese Mutual Health Scheme	18-11-01	110 minutes
Ashanti Region		
Civil Servants' Medical Insurance Scheme	16-11-01	55 minutes
Manhyia Susu Health Scheme	16-11-01	49 minutes
Brong Ahafo Region		
Tano Community Health Insurance Scheme	16-11-01	80 minutes
Nkoranza Health Insurance Scheme	19-11-01	86 minutes
Greater Accra Region		
Dodowa Community Health Insurance Scheme	- - - - - - - -	- - - - - - -
Northern Region		
Tiyumtaaba Welfare Association	19-11-01	26 minutes
Upper West Region		
South Sissala Health Insurance Scheme	16-11-01	46 minutes

2.2 Data Collectors and Entry

Dr. Sylvia J. Anie, Mr. George Kumih Kyeremeh, and Mr. Samuel George Anarwat collected the data (Table 2). Their areas of responsibility are indicated below in Table 3. Mr. Patrick Addae did data entry.

Table 2. Sampled MHOs

Region	Interviewer	MHO, City
Eastern Region	Dr. Sylvia Anie	St. Rose's Secondary School Health Insurance Scheme, Akwatia Methodist Church Koforidua Koforidua Diocese Mutual Health Scheme, Koforidua
Ashanti Region	George Kumih Kyeremeh	Civil Servants' Medical Insurance Scheme, region-wide Manhyia Susu Health Scheme, Kumasi
Brong Ahafo Region	George Kumih Kyeremeh	Tano Community Health Insurance Scheme, Tano Nkoranza Health Insurance Scheme, Nkoranza
Greater Accra Region	George Kumih Kyeremeh	Dodowa Community Health Insurance Scheme, Dangme West
Northern Region	Samuel George Anarwat	Tiyumtaaba Welfare Association, Tamale
Upper West Region	Samuel George Anarwat	South Sissala Health Insurance Scheme, Funsi

2.3 Study Constraints

2.3.1 Travel Constraints

The process of data collection generally involved significant travel due to the wide coverage of MHOs. This inherently introduced some difficulties in long travel times, particularly in the Northern and Upper West Regions.

For example, there is only one bus from Tamale to Wa. Due to the deplorable nature of the road, the bus broke down twice and whole day was spent traveling. In some cases, for example Wa to Funsi, private vehicles had to be hired to conduct the survey.

2.3.2 Dual Roles of MHO Managers

While most responding MHO managers showed a willingness to complete the questionnaire, there were many interruptions during the interviews as the managers were repeatedly called to deal with other matters. In anticipation of this some of the interviews were conducted on a Sunday and some in the homes of the respondents.

2.3.3 Inability to Contribute to Survey

There was only one example of an MHO manager who after three approaches was unable to provide information for the study: the Dodowa community health insurance scheme.

3. Findings

3.1 Schemes

3.1.1 St. Rose's Secondary School Health Insurance Scheme, Akwatia

This MHO was set up to provide health insurance to pupils at St. Rose's Secondary School, who are 12 to 18 years. St. Dominic's Hospital, a mission hospital and the largest district hospital in the area with specialist staff, initiated the scheme in January 2000. Interestingly, the initiator of the scheme is *also* the service provider, i.e., the service provider owns the scheme. The scheme was started also because the government's pilot scheme on health insurance in the Eastern region did not include this district, Kwaebibirem. The medical superintendent of the hospital, who also manages the scheme, agrees that pupils are a good group to insure because the risks are low.

Prior to acceptance by the scheme, a pre-insurance medical examination is performed, which enables the service provider to tailor services to the insured. This medical examination is borne by the school and costs cedis (¢) 45,000. Premiums are ¢25,000 per school term with ¢14,500 invested in the scheme and ¢10,000 invested in a health fund.

Payment is by capitation and the school negotiates with the provider on premium levels. The premiums are collected with the school fees and any differences between premiums and amounts paid by parents are invested in a health fund.

The socio-economic level of St. Rose's pupils varies from the rich, i.e., those with high earning professional parents, such as accountants, doctors, and civil servants, to middle-class pupils whose parents are teachers, technicians, etc., to the poor pupils whose parents may be unemployed or manual staff of the school, e.g., cooks, carpenters, etc.

Currently the subcommittee of the school's parents-teachers association has proposed that the school should own the scheme and St. Dominic's should serve solely as the service provider. This would enable the school to arrange for premium levels and services beneficial to them. The issue of quality would then also be more objective and not reliant on the service provider's judgment of its own services.

Due to the effectiveness of the scheme, other schools – Akwatia Technical, St. Mary's Girls Vocational School, Asamankese, and Pope John's, Akwatia – are considering health insurance schemes.

The concept of quality features strongly perhaps because the MHO manager is himself a medical practitioner and in his opinion the issue of quality is part of the formal contract. Also standards of quality and tools need to be improved and checklists established for all services and not left only to the Ministry of Health. Caution is required to check that service providers do not merely recommend high cost treatments and drugs in order to benefit from the scheme.

3.1.2 Koforidua Diocese Mutual Health Scheme

This scheme commenced in 2000 and is compulsory for all members of the church. There are 18 circuits forming the MHO and each circuit has a various number of societies.[1]

The societies keep ledgers of membership, which are sent to the circuits periodically. Presently it is difficult to ascertain the specific membership categories of the MHO because figures have not been compiled. This work however has commenced.

Many of the families in the scheme are the poor and/or unemployed. This has created some difficulties in setting the premium levels. Initially ¢1,000 per adult were proposed but after one year it is apparent that even ¢500 is too expensive for most members. To encourage premium collections, the frequency of the standard church collections has been reduced, and, out of the daily church collections, 30 percent is set aside for the MHO.

In general, premiums are based on a family's church contribution and therefore vary. It is expected that members pay ¢1,000 per week, which translates to ¢52,000 per year. The health benefits can be accessed one year after joining the scheme. Benefits can total ¢100,000.

A precondition of the insured is that they must be detained for at least 24 hours to benefit from the scheme. As a result uncomplicated deliveries are not covered.

There are gray areas though, for example, those critically ill with medical costs exceeding ¢100,000 are not covered; in this case the church contributes to the hospital costs. The generally accepted principle is that "you are your brothers' keeper" and the MHO serves to bring people together to support each other.

3.1.3 Nkoranza Health Insurance Scheme

The scheme was launched in 1992, following approval by district and regional levels of the Catholic Church.

Annual premiums are in cash co-terminus with the harvest season. The subscription unit is the family. Premiums are collected by field workers and assisted by the district co-coordinators.

The insurance package covers all admissions for medical, surgical, obstetric, and emergency care. Risk coverage is limited to hospital admission. Deliveries are covered only when complicated. Self-induced abortions are not covered. Clients admitted and referred from the hospital for treatment are reimbursed with the average inpatient bill for that month.

The service provider is St. Theresa's Hospital, the only referral hospital in the district. This has implications on quality, and there is no written contractual agreement between the scheme and the service provider.

1 The circuits are: Koforidua, Akwapim-Mampong, Aburi, Larteh, Adukrom, Kukurantumi, Osiem, Nkwakaw, Suhum, Nsawam, Atibie, Mpraeso, Maase, Mosiaso, Effiduase, Afram Plains, Apedwa and Akoase.

The service provider is St. Theresa's Hospital, the only referral hospital in the district. This has implications on quality, and there is no written contractual agreement between the scheme and the service provider.

3.1.4 Tano Community Health Insurance Scheme

The scheme started in March 2001, encouraged by the hospital administrator who obtained support from the community, i.e., the District Assembly, District Health Administration, traditional leaders, etc. A co-coordinator, who is a medical assistant, and a five-member management committee, manage the scheme.

An amount of ¢20,000 is paid as premium, out of which ¢5,000 is a registration fee. Though registration has been mainly individual based, full family registration is encouraged. Members who register have to wait for a period of one year before they can enjoy benefits. The number of persons registered stands around 1,000.

The scheme covers admissions and selected outpatient cases, including snake and dog bites and complicated labor. Non-complicated deliveries are not covered.

Lack of personnel and funds to support the scheme are present challenges and this may impinge on quality.

The scheme has not started to implement benefits. Some of the questions were therefore answered *prospectively*. There were a lot of interruptions as the coordinator (respondent) had to provide curative care in addition to the onerous task as scheme manager.

3.1.5 Ashanti Region Civil Servants' Medical Insurance Scheme

This scheme was established in 2000 to cover all civil servants and pensioners in the region. The scheme was conceived in response to the abuse and other problems associated with the implementation by the government of the current civil servants health refund system. The implementation of the scheme is a collaborative effort of the Ashanti Regional Health Administration and the Civil Servants Association.

Currently, the scheme covers 13,000 civil servants and three dependants less than 18 years. Each member contributes ¢5,000 per month, deducted at source.

The scheme is still embryonic and plans are underway to ensure health institutions provide a quality service by a team made up of the Ministry of Health and the Civil Servants Association.

The MHO manager demonstrated enthusiasm and high-level commitment to the scheme particularly on issues to do with quality. For example, *there was a written contract for the operation of the scheme, which had aspects of quality, especially on client's satisfaction.*

3.1.6 Dodowa Community Health Insurance Scheme

The Research Unit of the Ministry of Health, the Health Economics and Financing Programme, and London School of Hygiene and Tropical Medicine established this project in January 2001. It covers outpatient and referred cases.

In the first year, it was projected that 40 – 50 percent of the district population of 96,000 would subscribe to the scheme. However, with an enrollment of barely less than 5,000, approximately five percent of the population, there appears to be a need to educate the public about the scheme.

Major challenges faced by the scheme include non-availability of permanent staff.

The District Director of Health Sector, who was to be interviewed, was not available during the first visit. Subsequent visits also proved futile. The Director's major complaint was that most of the information needed is yet to be compiled; hence, she could not provide information on the prevailing situation.

The research was discontinued after the third contact.

3.1.7 Manhyia Susu Health Scheme

This scheme was established in November 2000 to remove financial barriers during delivery. The Susu system encourages participation and regularizes attendance to the clinic. An interim committee of five members from the hospital and 10 external members administer the scheme at the moment. There is relatively lower participation on the part of those outside.

Delivery service at the hospital is ¢40,000 and members contribute any amount when pregnant. The delivery service is deducted from the accumulative savings. After delivery, the mother may either decide to collect the difference and discontinue membership or continue as a permanent member.

Members from the Susu need not queue to be seen to and beverages are served during delivery. On occasion baby clothing is provided.

3.1.8 Tiyumtaaba Welfare Association

Tiyumtaaba Welfare Association is a cluster of community-managed MHOs in the Sagnerigu Health Subdistrict of the Tamale District of Northern Ghana. The scheme commenced in 1998.

The MHO comprises eight communities. Scheme management is decentralized to the community level, and each community has a management committee. The composition takes gender into account. Beneficiaries of this scheme are given a credit facility to pay for their health care cost, usually for admission cases and complicated deliveries.

3.1.9 South Sissala Health Insurance Scheme

The South Sissala Health Insurance Scheme is a community-based and community-managed MHO still in its gestational phase with an envisaged coverage of 30,000 members. It is located 112km east of Wa, in the Upper West Region of Ghana.

Many activities have been held such as mini-stakeholder workshop, pre-feasibility studies, and community durbar in preparation for the launching of the scheme. A draft constitution has been drawn and responses are therefore based on proposals embodied in the draft constitution.

3.2 Limitations in MHO Data Collection and its Effect on Quality of Care

The survey clearly indicates problems that the schemes need to address as these problems invariably impinge on quality of health services provided by the service provider. Each issue is discussed separately.

3.2.1 Embryonic Status of MHOs

A large proportion of the MHOs interviewed are in the gestational phase. Thus, without experience, many responses were prospective, and it was generally difficult to obtain information on the numbers of women, children, and newborns who belong to the scheme. For example, the Tano Health Scheme commenced in March 2001 and thus benefits had not begun and monthly volumes could not be obtained. Furthermore, formal contracts did not exist. In Sissala, the responses were based on proposals in the constitution, as the scheme had not been imeplemented.

3.2.2 Poor Record Keeping and Documentation

Record keeping was poor for most of the MHOs interviewed and in some cases the records were inaccessible. This required some degree of estimation and approximation in answering the questions.

For example, even though the Nkoranza Community Health Insurance Scheme has existed for nine years, figures relating to numbers of women, children, and newborns could not be obtained because the register was unavailable. No formal contract was in use either.

In some cases, for example Tiyumbaata, the scheme manageress was unable to provide the needed information as changes had been made to their records due to new entrants and the executive committee members at the various communities keep the record books. It was necessary to visit the communities to meet the MHO community committee executives to review their records. Some of them were not readily available.

With the Manhyia Susu Health Scheme, and the Tiyumbaata Welfare Association, monthly volumes of services provided could not be obtained, as registers were not complete.

3.2.3 Lack of Administrative Set-up to Underpin Scheme

With the Manhyia Susu Health Scheme, it was observed that due to the lack of office facilities for the scheme coordinator, administration of the scheme was not well coordinated, documented, or centralized, and thus information was fragmented. The medical officer, however, was co-operative when there was need for the MHO manager to crosscheck information.

3.2.4 Over-reliance on the Ministry of Health to Determine Quality of Services

In most cases the standards of service delivery expected from the service providers is left with the Ministry of Health to apply and enforce. MHO managers have so far contributed little or not at all to the setting of quality standards. This was noted for the health schemes in Manhyia, Tano, Nkoranza, Tiyumtaaba, and South Sissala.

3.2.5 Monitoring of Health Services by Provider

It was noted that although formal contracts did not exist for five of the MHOs interviewed (Table 3), there were still ongoing monitoring activities, 75 percent to check on the quality of care by the service provider. This was observed at the St. Rose's, Methodist Church, Civil Servants', Manhyia Susu, Nkoranza and Sissala schemes.

Two MHOs, Tano Community Health Insurance Scheme and Tiyumtaaba Welfare Association, had no formal contract and no monitoring activity (Table 3).

Table 3. Mutual Health Organizations, Quality of Care, Existance of Formal Contracting and Monitoring and Frequency of Monitoring

MHO	QM	QC	FC	M	FOM
St. Rose's	Most Important	Important	Yes	Yes	Every Week
Methodist	Most Important	Very Important	Yes	Yes	Every Month
Civil Servants'	Most Important	Most Important	Yes	Yes	As and When
Manhyia	Most Important	Most Important	No	Yes	Every Week
Tano	Very Important	Very Important	No	No	None
Nkoranza	Most Important	Most Important	No	Yes	As and When
Tiyumtaaba	Very Important	Very Important	No	No	None
Sissala	Very Important	Very Important	No	Yes	Quarterly

MHO=Mutual Health Organisation
QM= Quality as perceived by MHO manager
QC= Quality as perceived by client
FC= Existence of formal contract
M= Existence of monitoring activities
FOM=Frequency of monitoring

3.2.6 Inclusion of HIV-positive Clients

It was encouraging to note that 78 percent of the MHOs cover HIV-seropositive people in their membership. (South Sissala and Tiyumtaaba schemes do not.) The kind of HIV/AIDS services covered ranged from prevention to treatment, care and support.

4. Conclusions

Overall the respondents were able to understand most of the questions. However the respondents perceived a few open-ended questions as ambiguous, and there was the need to clarify terminology, etc.

Generally the concept of quality is foremost in the considerations of the MHO managers. The managers are able to define quality and demonstrate an appreciation of quality care and what it means to communities.

However, because the contracting process in most cases is informal, there is the need to encourage the MHOs to integrate quality of services into the contracting process. Work remains to be done in translating the aspirations of quality criteria into reality.

As a result, there were no instances of action being taken against providers not performing up to the minimum standards. Nevertheless, the respondents largely agreed that monitoring to check on the services being provided was essential and most monitored the provider regularly.

Most of the MHOs are embryonic and are experimenting with ideas on the best way forward: setting premium levels, selection of providers, qualifying criteria for the insured, etc.

The MHOs play an active role in health promotion activities. This was observed for all MHOs particularly in the area health education sessions.

There appeared not to be discrimination against those who are HIV-positive in terms of coverage under the scheme. The two regions not offering HIV/AIDS coverage, i.e., Northern and Upper West, also happen to be amongst the lowest-prevalence areas in Ghana with HIV/AIDS prevalence rates of 1.4 percent and 1.5 percent respectively (as compared to the Ashanti, Eastern, Greater Accra regions where prevalence is approximately 2.7 percent, 5.3 percent and 3.1 percent respectively.) Therefore some parallels may be drawn in relation to the lower perception of risk so far as HIV/AIDS issues in the lower-prevalence areas.

It is hoped that these results will help indicate the current perception of quality, in particular in the way the MHOs operate and the extent to which quality is integrated into the MHO – provider arrangements.

Annex

PHR*plus* MHO Quality Questionnaires

10/25/01

Introduction

Hello, my name is _____. I am working with the Partnerships for Health Reform Plus project on the creation of training materials for providers and MHO managers on aspects of quality of health care. I would like to ask you a few questions about quality of health care and its importance to your MHO and the households your MHO serves. All the responses we collect will be kept confidential and will only be used for research purposes to better understand the situation of MHOs in Ghana and to develop these training materials.

Background

(Interviewers – Try to fill out this information as much as possible in advance so as to not waste time during the interview)

NAME OF MHO _____						
LOCATION OF MHO (VILLAGE) _____						
LOCATION OF MHO (REGION) _____						
DATE OF FIRST CONTACT:						
	D	**D**	**M**	**M**	**Y**	**Y**
TIME AT START OF FINAL CONTACT:						
			h	**h**	**m**	**m**
NAME OF INTERVIEWEE/ MHO MANAGER _____						
TITLE OF INTERVIEWEE _____						
NAME OF INTERVIEWER _____						

	INTERVIEWS			**FINAL RESULT**	
	1	**2**	**3**		
DATE OF CONTACT				**DATE OF LAST CONTACT**	
***RESULT**				**DAY**	
				MONTH	

****FOLLOW UP INTERVIEW FOR:**						
	DATE:					
	HOUR:				*	**FINAL RESULT**
****(IF INTERVIEW ISN'T FINISHED)**						
*** CODES**	**1 COMPLETE 2 NOT THERE 3 DEFERED 4 REFUSED 5 PARTIALLY COMPLETE 6 OTHER (explain at right)**					

QUALITY CONTROL						
MANAGER:				**DATA ENTRY:**		
CODE: (circle)	**OK**	**Not OK**		**CODE: (circle)**	**OK**	**Not OK**
INITIALS				**INITIALS**		
DATE:				**DATE:**		

Structure of MHO

Number of members of MHO _____

Can you give me the number of women of childbearing age who are members of the MHO (age 15-44)? *(Interviewers, ask to see the register of members if possible. If not, ask your interviewee to estimate.)*

_____

Can you give me the number of children in families who are members of the MHO (age <5)? *(Interviewers, ask to see the register of members if possible. If not, ask your interviewee to estimate.)*

_____

Can you give me the number of newborns (children born in the last year) in families who are members of the MHO? *(Interviewers, ask to see the register of members if possible. If not, ask your interviewee to estimate.)*

_____

Can you estimate the socioeconomic level of the families served by the MHO? Please give me your estimate of the percentage of poor, middle class and rich families served by the MHO. *(Interviewers – This should add to 100%)*

Poor _____ (%)

Middle class _____ (%)

Rich _____ (%)

How is the MHO managed?

By clinic provider	1
By community committee	2
By private board	3
Other (Describe below)	4

_____

_____

Don't know 99

Selecting providers

Do you work with more than one provider?

Yes 1

No 2

Don't know 99

Number and type of providers with whom you work

Type	Number
Public (Ministry of Health)	
Private for-profit	
Private not-for profit (NGO)	
Traditional (birth attendants, traditional healers)	
Religious	

Please describe how you selected the providers with whom you work?

_____

_____

_____

What things are important to look for when choosing a provider for the MHO? *(Interviewers – note the responses without reading the choices)*

Provider is competent and well trained 1

Clients say that they are satisfied with the provider 2

Provider is effective in treating patients and gets good outcomes	3
The health facility is always tidy and clean	4
The provider is very welcoming to his/her patients and explains well what he/she is doing	5
The provider always has drugs available	6
The provider is close (geographically) to our community	7
Services are affordable	8
Provider is able to refer patients to more specialized services or hospital when necessary	9
Other (explain below)	10

_____

Don't know 99

Health care services provided

What services are covered under the MHO? What is the monthly volume? What aspects of services are covered (care, drugs, transport)? *(Interviewers – read the services in the left column and fill in the appropriate information in the boxes provided. If possible, request to see a register for the MHO in order to get accurate numbers for column 3, Monthly volume)*

Services	**Provided?**	**Monthly volume**	**Aspects of services covered**			
	(Place an "X" where appropriate)	(Number)	**Care** Place an "X" where appropri-ate	**Drugs** Place an "X" where appropriate	**Transport** Place an "X" where appropri-ate	**Other** (explain)
Outpatient consultations						
Inpatient hospital stays						
Prenatal consultations						
Deliveries						
Postnatal care						
Breastfeeding counseling						
Vaccinations						
Family planning counseling						
Family planning products						
Condoms						
Pills						
IUD						
Norplant						
Vasectomy						
Laboratory work						

Blood tests/transfusions (for HIV or otherwise)						
Vitamin A pills/ supplementation						
Oral rehydration solution/ therapy						
Others (list below)						

Does the MHO conduct programs to promote healthy behaviors by its members or to promote preventive health services?

Yes 1 (If Yes, go to **14**)

No 2

Don't know 99

If you do not do any promotion of healthy behaviors or preventative health services, why not?

_____

_____

_____

What health behaviors or preventive health services do you promote? *(Interviewers – circle yes or no in the table below. Read each item in column 1 to your interviewee)*

Health promotion sessions	Cover?		
Immunizations	Y (1)	N (2)	NA (99)
Vitamin A supplement	Y (1)	N (2)	NA (99)
Proper breastfeeding	Y (1)	N (2)	NA (99)
ORS for diarrhea	Y (1)	N (2)	NA (99)
Avoiding malaria (bed net use, etc.	Y (1)	N (2)	NA (99)
ARI/pneumonia	Y (1)	N (2)	NA (99)

What form of health promotion do you use for these services?

Health education sessions in community 1

Leaflets 2

Individual counseling sessions 3

Other (explain below) 4

_____

Don't know 99

How were the services in the table above (question #11) chosen? Please describe the process.

_____

_____

_____

I would like to ask you about coverage for HIV. Does your MHO cover HIV seropositive people in your membership pool?

Yes 1

No 2 (If No, go to **19**)

Don't know 99

What kind of HIV/AIDS services do you cover in your MHO? *(Interviewers – check all that apply).*

Prevention 1

Treatment 2

Care 3

Support 4

Don't know 99

How many people in your MHO membership pool are HIV/AIDS seropositive?

1 – 9	1
10 – 49	2
50 – 99	3
100 - 150	4
More than 150	5
Don't know	99

(Interviewers – skip this question if #17 above is "Yes")

If the MHO does not cover benefits for seropositive people, where do they go for treatment?

To a government/public hospital	1
To a government/public health center/clinic	2
To a private/NGO clinic	3
To a traditional healer	4
Other (explain below)	5

_____

Don't know 99

Quality of services

In general, do you feel that quality of care is an important concern for you as an MHO manager? *(Interviewers – read the choices to the interviewee)*

The most important aspect of our work 1

Very important 2

Important 3

Not very important 4

Not at all important 5

Don't know 99

How important is quality of care to your clients? *(Interviewers – read the choices to the interviewee*

The most important aspect of our work 1

Very important 2

Important 3

Not very important 4

Not at all important 5 (Skip to #24)

Don't know 99

What do you think is the most important thing that your MHO members think about when making the decision to seek care? *(Interviewers – note the responses without reading the choices)*

Provider is competent and well trained 1

Clients say that they are satisfied with the provider 2

Provider is effective in treating patients and gets good outcomes 3

The health facility is always tidy and clean 4

The provider is very welcoming to his/her patients and explains well what he/she is doing 5

The provider always has drugs available 6

The provider is close (geographically) to our community 7

Services are affordable 8

Provider is able to refer patients to more specialized services or hospital when necessary 9

Health facility is open at convenient hours and waiting lines 10

Other (explain below) 11

_____

Don't know 99

Do you know of standards of service delivery, that is statements of what quality of care is expected from providers, that are used in your community? In what areas of health care delivery are these standards that you know? *(Interviewers – note the responses without reading the choices)*

Curative services for:

Sick child care 1

Vaccinations 2

Prenatal/postnatal care 3

Deliveries 4

Acute respiratory infections 5

Tuberculosis 6

Diarrheal disease 7

Malaria 8

Counseling services for:

Breastfeeding 9

HIV/AIDS/STIs 10

Breastfeeding 11

Good interpersonal communication 12

Drug stock management 13

Cleanliness and physical appearance of facility 14

Other (explain below) 15

_____

Don't know of any standards 99 (Skip to #26)

Where do the standards you mentioned above come from?

_____

_____

Relationship with providers

Please describe your arrangements with providers. *(Interviewers – You may prompt the interviewee if necessary. "How do you manage making payments to providers regularly? How do providers 'bill' you for services they give to clients covered under the MHO?" If possible, also ask for copies of the contracts if they exist)*

_____

_____

_____

Is there some sort of formal "contract"? *(Interviewers – You may explain that by "contract" we mean some sort of document that describes what the MHO will do for providers and what the providers will do for the MHO).*

Yes 1

No 2 (If No, go to **31**)

Don't know 99

Please describe the elements of that contract.

_____

_____

_____

Does quality enter into the contracting process? That is, do you set minimum standards for care delivery, in either cleanliness, services provided, quality of services or client satisfaction when you contract with providers?

Yes 1

No 2 (If No, go to **31**)

Don't know 99

Which areas of health care quality enter into the contracting process?

Provider's competence and training 1

Clients satisfaction with the provider 2

Provider is effective in treating patients and gets good outcomes 3

Cleanliness of the health facility 4

Provider's interpersonal communication 5

Drug availability at the facility 6

Services are affordable 7

Provider is able to refer patients to more specialized services or hospital when necessary 8

Other (explain below) 9

_____

Don't know 99

Do you monitor the providers with whom you work? That is, do you check to make sure that the providers you are paying are providing adequate services and meeting contract or other agreement requirements?

Yes 1

No 2 (If No, go to **37**)

Don't know 99

How do you monitor providers? *(Interviewers – check all that apply)*

Visit the clinic	1
Visit the clinic and review	2
Conduct observations of provider with patients	3
Interview clients as they leave the facility	4
Other (explain below)	5

_____

How often do you monitor these providers?

Every week	1
Every month	2
Every three months	3
Every year	4
Other (explain below)	5

_____

Who conducts this monitoring?

_____

In your opinion, is it an effective means to assess the quality of care that the MHO members receive?

Yes	1
No	2
No opinion	99

Why or why not?

_____

_____

Do you solicit the opinions of the households and communities that are contributing to the MHO in terms of the quality of services they receive?

Yes 1

No 2 (If No, go to **41**)

How do you solicit these opinions? *(Interviewers – check all that apply.)*

Word of mouth 1

Suggestion box 2

Visiting and interviewing members at home 3

Interviewing members at clinic 4

Focus groups with members 5

Other (explain below) 6

_____

Don't know 99

Who collects this information from clients?

_____

How often do you collect it?

Every week 1

Every month 2

Every three months 3

Every year 4

Other (explain below) 5

_____

What steps have you taken, if any, when for providers that are not performing up to the minimum standards you expect?

_____

_____

_____

What else do you think is important for us to know about quality of care within your MHO?

_____

_____

_____

That is all the questions I have for you. Do you have any questions for me?

Thank you very much for taking the time to speak with me. This information will be very useful for our team in developing training materials for MHOs in Ghana and in researching the situation of MHOs in Ghana.

END OF INTERVIEW

TIME AT END OF INTERVIEW

H	H	M	M